RECOMMENDATION FOR FOSTER FAMILY HOME CARE LICENSE OR RELATIVE HOME CARE LICENSE

State Form 17769 (R8 / 10-04) / FPP 0335

Family and Social Services Administration
Division of Family and Children
402 West Washington Street, Room W364, MS08
Indianapolis, Indiana 46204

INSTRUCTIONS:

1. Complete 2 copies. KEEP 1 COPY FOR YOUR AGENCY RECORD.
2. Send original recommendation to FSSA, Division of Family and Children.
3. Copy of approval of recommendation will be returned to county or private agency.
4. Copy will be filed in the license file.

1. Foster family home license recommendation ☐ a. Regular Foster Family Home ☐ Relative Home ☐ b. Special Needs Foster Family Home ☐ c. Therapeutic Foster Family Home ☐ a. IVE ☐ b. Non - IVE	Evaluation: ☐ New ☐ Renewal ☐ Revised ☐ Deny / Revoke ☐ Suspend ☐ Close
Quarter to which license is being assigned: ☐ APR (1) ☐ JUL (2) ☐ OCT (3) ☐ JAN (4)	Expiration date / renewal date of current license (*month, day, year*) (*not applicable if new evaluation*)

CENTRAL OFFICE / COUNTY USE ONLY

Enter resource ID number assigned by the Indiana Child Welfare Information System (ICWIS). If the number is less than 9 digits, use zeros for first spaces.												

GENERAL APPLICANT INFORMATION

Name of agency			
Complete address of agency (*Indiana county offices may omit*)			
Surname of foster family / relative	Street address of foster family / relative home (*location address is required for license*)		
City of foster family / relative home	ZIP code of foster family / relative home	County of foster family / relative home	Telephone number of foster family / relative home
Full name of Applicant A:			Date of birth (*month, day, year)*
Occupation	Marital status	Social Security number	Race
Full name of Applicant B:			Date of birth (*month, day, year*)
Occupation	Marital status	Social Security number	Race

OTHER HOUSEHOLD MEMBERS. DO NOT LIST FOSTER CHILD(REN) FOR REASONS OF CONFIDENTIALITY

NAME OF HOUSEHOLD MEMBER (*LIST ALL OTHER MEMBERS IN HOME*)	RELATIONSHIP TO APPLICANT	DATE OF BIRTH (*month, day, year*)	UNDER 18 (Y/N)	UNDER 6 (Y/N)

SUMMARY OF HOUSEHOLD AND FOSTER FAMILY HOME LICENSING CAPACITY

Number of household children under age eighteen (18).		Number of household children under age six (6).		NAMES / DATE OF BIRTH OF CHILDREN IN RELATIVE HOME FOR IV-E-FC:
Number of foster children under age eighteen (18) for license.		Number of foster children under age six (6) for license (*limit is 4*).		
Total number of household children plus foster children.		Total number of household children and foster children under the age of six (6).		

(*RECOMMENDATION CONTINUES ON THE REVERSE SIDE*)

LICENSING AGENCY RECOMMENDATION TO LICENSE

Original application filed (*month, day, year*)	Current application filed (*month, day, year*)	Juvenile records check
		Adults ☐ Yes ☐ No Date completed: _____ Juveniles ☐ Yes ☐ No Date completed: _____

TO BE COMPLETED BY COUNTY OR PRIVATE AGENCY		COMMENT OR EXPLANATION
Initial Homestudy Assessment	☐ YES ☐ NO	Date of assessment:
Annual Relicensing Assessment (*check one*)	☐ YES ☐ NO	Date of assessment:
Application for foster family home license approved?	☐ YES ☐ NO	Date of assessment:
Relative home (IV-E or Non-IVE) license approved?	☐ YES ☐ NO	Date of assessment:
Use / purpose:		Any substantiated or indicated child protection service (CPS) investigations for this family?
Regular?	☐ YES ☐ NO	☐ YES ☐ NO
Intermediate or emergency care?	☐ YES ☐ NO	
Special needs?	☐ YES ☐ NO	
Therapeutic home?	☐ YES ☐ NO	
Handicapped, mentally retarded children accepted?	☐ YES ☐ NO	
Relative only?	☐ YES ☐ NO	
WATER ANALYSIS APPROVAL ON FILE?	☐ YES ☐ NO	Date approved:
SMOKE ALARM RECOMMENDED BY FAMILY CASE MANAGER? If YES, attach signed, dated Physical Environment Checklist	☐ YES ☐ NO ☐ N/A	Date Checklist completed: _____
APPLICANT'S STATEMENT OF ATTESTATION?	☐ YES ☐ NO	Date of statement: _____
CHILD PROTECTION SERVICES CHECK COMPLETED?	☐ YES ☐ NO	
CRIMINAL HISTORY CHECK COMPLETED?	☐ YES ☐ NO	Date of check: _____

COUNTY OR PRIVATE AGENCY SPECIAL LICENSING RECOMMENDATIONS OR REQUESTS

RECOMMENDATION		SIGNATURE	APPROVAL DATE	NON-APPROVAL DATE
PROBATIONARY LICENSE IS REQUIRED?	☐ YES ☐ NO			
(*Documentation is attached citing the violation and referencing the applicable rule?*)	☐ YES ☐ NO			
EXCEPTION,WAIVER OR VARIANCE REQUEST SUBMITTED TO CENTRAL OFFICE LICENSING MANAGER? 470 IAC _____ IC 12-17 _____	☐ YES ☐ NO			
OTHER CONDITIONS? (*Explain*)	☐ YES ☐ NO			
FIRST AID, CPR, AND UNIVERSAL PRECAUTIONS COMPLETED?	☐ YES ☐ NO			
REQUIRED INITIAL FOSTER PARENT/RELATIVE TRAINING HOURS COMPLETED ARE:	Applicant A: _____ Applicant B: _____	Date completed _____ Date completed _____		
CONTINUING ANNUAL FOSTER PARENT/RELATIVE TRAINING HOURS COMPLETED ARE:	Applicant A: _____ Applicant B: _____	Date completed _____ Date completed _____		

The above-named applicants for foster family home licensure or relative home licensure have met the requirements as contained in 470 IAC and IC 12-17.4-4. A signed application for a foster family home or relative home license and a foster family / relative home preparation and assessment are complete and on file in the agency.

Signature of licensing family case manager:	Date:
Signature of county agency or private agency executive designated to authorize recommendations to FSSA / DFC:	Date:

LICENSING AGENCY RECOMMENDATION TO DENY APPLICATION, REVOKE LICENSE, SUSPEND LICENSE / APPROVAL, OR CLOSE CASE FILE

☐ 1. Deny application - Reason: 470 IAC (*Attach documentation*)
☐ 2. Revoke a license / approval - Reason: 470 IAC (*Attach documentation*)
☐ 3. Suspend license / approval - Reason: 470 IAC (*Attach documentation*)
☐ 4. Case file closed - Reason:

FSSA ACTION:

(*Check one*) ☐ A. Voluntary Withdrawal ☐ B. Transfer to _____ (*list agency*) ☐ C. Relocation ☐ D. Failure to Respond ☐ E. Other _____

The above-named home applicants for foster family home licensure / relative home licensure have not met the requirements as contained in 470 IAC and IC 12-17.4-4.

Signature of county agency or private agency executive designated to authorize recommendations to FSSA / DFC:	Date:

ACTION OF THE FAMILY AND SOCIAL SERVICES ADMINISTRATION

FSSA action date:	Effective date	Expiration date
Entered by:		

Signature of Deputy Director, Division of Family and Children